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# **COMPREHENSIVE PERINATAL CARE PROGRAM**

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**Richard P. Kusserow  
INSPECTOR GENERAL**

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## EXECUTIVE SUMMARY

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### PURPOSE

The purpose of this inspection was to assess the initial implementation of the Comprehensive Perinatal Care Program (CPCP), an initiative of the Public Health Service (PHS) to reduce infant mortality. The specific issues examined in this inspection concerned: (1) the extent to which CPCP grantees' goals and objectives have met stated program criteria; (2) the extent to which PHS has conducted oversight of the CPCP grantees; and, (3) the extent to which the CPCP funds have been distributed to areas experiencing high infant mortality rates for the general and minority populations.

### BACKGROUND

This report examines one Department initiative directed at reducing the nation's high infant mortality rate, the Comprehensive Perinatal Care Program (CPCP). The CPCP provides supplemental funds for enhancing perinatal care systems in community and migrant health centers (C/MHC). The purpose of the CPCP has been to improve the pregnancy outcomes and health status of women and infants served by these centers. The OIG's interest in the CPCP initiative is based on the Department's continuing concern over the nation's high infant mortality rates and the growing investment being made in this initiative. The inquiry was based on: (1) discussions with PHS staff in headquarters and regional offices who were involved in the CPCP grant application review process and ongoing grantee oversight; (2) discussions with Congressional staff familiar with the legislative history of the CPCP; (3) review of relevant documents for the C/MHC program and CPCP initiative including program guidance and application guidance memoranda, CPCP grant applications and application review protocols, and approved budgets and data on perinatal users for all FY 1988 CPCP grantees; (4) a review of recent relevant studies and evaluations of infant mortality and perinatal care services; and (5) census and infant mortality data from the National Center for Health Statistics.

### FINDINGS

*The goals and objectives set forth in CPCP grant proposals approved by PHS have been in accord with the intended purposes of the program.*

*In some cases, PHS had limited information on how grantees planned to spend the CPCP funds awarded during the first year.*

*The PHS has established a basic framework for gathering information useful for assessing the impact of CPCP services, although it is too soon to have been tested.*

*Many areas of the country with high rates of infant mortality have not been receiving CPCP funds.*

- Approximately 25 percent of CPCP funds have been awarded to community and migrant health centers serving areas with infant mortality rates below the threshold established by PHS for high infant mortality—12 deaths per 1,000 live births.
- Almost half of all community and migrant health centers have not applied for CPCP funds while others—including those serving areas with high infant mortality rates—have applied and have been disapproved.
- Nearly half of the nation’s largest cities with high infant mortality rates—greater than 12 deaths per 1,000 live births—have not been eligible for CPCP funds because they have no centers funded through sections 329/330 of the Public Health Service Act.

## **RECOMMENDATIONS**

*The PHS should strengthen its procedures for approving CPCP grants to assure adequate accountability for CPCP funds.*

*The PHS should strengthen its efforts to provide technical assistance to community and migrant health centers preparing CPCP grant proposals.*

*The PHS should reexamine the approach for allocating CPCP funds to assure that these funds are directed to areas of high infant mortality.*

## **COMMENTS**

We received comments from the Assistant Secretary for Planning and Evaluation and the Public Health Service. Both agencies concurred with our recommendations. Their detailed comments on the draft report and our responses to them appear in the final section of this report.

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## INTRODUCTION

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### PURPOSE

The purpose of this inspection was to assess the initial implementation of the Comprehensive Perinatal Care Program (CPCP), an initiative of the Public Health Service (PHS) to reduce infant mortality. The specific issues examined in this inspection concerned:

1. The extent to which CPCP grantees' goals and objectives have met stated program criteria;
2. The extent to which PHS has conducted oversight of the CPCP grantees; and,
3. The extent to which the CPCP funds have been distributed to areas experiencing high infant mortality rates for the general and minority populations.

### BACKGROUND

#### *Infant Mortality in the United States*

Infant mortality is a serious problem in the United States. In 1987, the United States ranked 21st among industrialized countries in its rate of infant mortality<sup>1</sup>—10.1 deaths per 1,000 live births.<sup>2</sup> Although infant mortality rates in the United States have decreased during the past decade, the rate of decline has slowed in recent years.<sup>3</sup> This is largely because the incidence of low birthweight births—a major factor influencing infant mortality—has declined only slightly during this period.<sup>4</sup>

Infant mortality rates among certain ethnic groups and in certain urban and rural geographic areas remain high, and in some instances, have been increasing. In 1987, for example, the national infant mortality rate for blacks was 17.9 deaths per 1,000 live births—twice the rate of 8.6 deaths per 1,000 live births for whites.<sup>5</sup> In 1986, the infant mortality rate was 21.1 deaths per 1,000 live births in Washington, D.C., 20.3 in Detroit, and 16.3 in Cleveland.<sup>6</sup> For the first 6 months of 1989, Washington, D.C. reported an unprecedented infant mortality rate of 32.2 deaths per 1,000 live births.<sup>7</sup>

The nation's high infant mortality rates have, over the years, attracted widespread attention from the public, health professionals, and the government. Ten years ago, the Department of Health and Human Services (HHS) set national goals for improving the health of Americans by 1990. Several goals focussed specifically on infant mortality. One of these stipulated that, by 1990, the national infant mortality rate not exceed 9 deaths per 1,000 live births and another that no county and no racial or ethnic group have infant mortality rates greater than 12 deaths per 1,000 live births.<sup>8</sup>

### ***HHS Efforts to Reduce Infant Mortality***

The Department of Health and Human Services (HHS) has long supported programs aimed at reducing infant mortality through improved health care for mothers and infants. Beginning in 1935, Title V of the Social Security Act authorized grants to the States for services to promote maternal and child health. Over the years, Title V has been amended a number of times, although the goal of promoting the health of mothers and children, especially those at risk for poor health, has remained the same.<sup>9</sup>

In 1981, Title V was amended to establish the Maternal and Child Health Services Block Grants which provided consolidated funding to the States for the various categorical programs which had been supported under Title V. The States have used the block grant funds to support a variety of health service programs, including those aimed at reducing infant mortality. These infant mortality initiatives may be strengthened in the years ahead because of a new Federal set-aside provision contained in Omnibus Reconciliation Act of 1989. This provision prescribes a certain percentage of funds from the MCH block grant appropriations be set aside specifically for infant mortality initiatives with preference being given to projects in areas with higher than average infant mortality rates.<sup>10</sup>

Further, the Medicaid program (Title XIX of the Social Security Act) has, since the mid-1960s, provided an important source for financing health services, including prenatal and postnatal care, for low income women and infants. Since the mid-1980s, Congress has sought to expand Medicaid coverage for pregnant women and children through various options and mandates to the States.

### ***Community and Migrant Health Centers and the Comprehensive Perinatal Care Program***

Community and migrant health centers (C/MHCs) have been another major cornerstone of Departmental efforts to reduce infant mortality. Since the early 1970s, PHS has provided financial support to C/MHCs, which provide comprehensive primary health services in medically underserved areas. Currently, PHS supports approximately 600 C/MHCs through grants funded under sections 329 and 330 of the Public Health Service Act and through the National Health Service Corps (NHSC) which provides health personnel such as nurse practitioners, obstetricians, and pediatricians to many centers. The C/MHCs serve nearly six million people, most of whom are poor, uninsured or insured by Medicaid, and members of minority groups.<sup>11</sup>

The PHS requires C/MHCs to provide perinatal care services among other types of primary health services. Perinatal care includes medical, educational, and social support services provided to pregnant women and infants from conception through postpartum and newborn care.<sup>12</sup> Experts have long recognized that comprehensive perinatal services are critical in assuring healthy pregnancy outcomes and in reducing infant deaths.<sup>13</sup> Equally important are access to early and continuous prenatal care services; case management, whereby one person, the case manager, coordinates clients' services; and, one-stop-shopping, meaning the

integration of comprehensive perinatal care with other specialized services. These approaches to care are emphasized by C/MHCs.

Recently, the Congress and the Department became increasingly concerned over the slowing decline in the nation's infant mortality rates and the possibility that the Surgeon General's goals for reducing these rates by 1990 would not be attained. They agreed on the need to bolster Departmental efforts to reduce infant mortality given that also during this period, Federal appropriations for the C/MHCs were being reduced, Federal support for the NHSC was declining, and medical malpractice costs were soaring.<sup>14</sup> Thus Congress appropriated additional funds for a special infant mortality initiative in FY 1988. The PHS used these funds to develop and implement the Comprehensive Perinatal Care Program (CPCP) in C/MHCs.

The purpose of the CPCP initiative has been to improve the pregnancy outcomes and health status of women and infants served by the C/MHCs and thereby reduce infant mortality in these communities. The PHS has used the CPCP funds to supplement—or, in some cases, to maintain—the existing perinatal services offered by the centers, rather than to demonstrate innovative approaches for reducing infant mortality. This strategy has been consistent with the intent of Congress which has, through various appropriations and authorization documents, made clear that these funds should support expanded capacity and enhanced services in the centers.<sup>15</sup>

The PHS awarded 207 CPCP grants in FY 1988 and 263 grants in FY 1989. In both FY 1988 and FY 1989, PHS established application and review processes for the CPCP funds which were separate from the process followed for the centers' regular 329/330 funding.<sup>16</sup> The CPCP initiative is administered in PHS by the Division of Special Populations Program Development, Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration.

The short history of the CPCP initiative illustrates the growing investment being made by the Congress and the Department in this program. As the first CPCP grants became operational in 1989, former Secretary of Health and Human Services, Dr. Otis R. Bowen, referred to the CPCP as the "leading edge of DHHS' total efforts to reduce infant mortality."<sup>17</sup> Moreover, funding for the initiative, which is a separate line item in the budget, has increased steadily. Congress appropriated \$20.1 million in FY 1988, \$20.5 million in FY 1989, and \$32 million in FY 1990. The FY 1991 President's Budget includes a request for \$36 million for the CPCP—which, if appropriated, would represent an 80 percent increase in CPCP funding since FY 1988.

In view of the continuing concern over the country's high infant mortality rates and the enhanced investment being made in the CPCP, we examined this initiative to assist the Department in strengthening its efforts to reduce infant mortality. Accordingly, this report presents our findings related to the implementation of the CPCP and concludes with recommendations to PHS regarding the management of this initiative.

Sources of information for this study included: (1) discussions with PHS staff in headquarters and regional offices who were involved in the CPCP grant application review process and ongoing grantee oversight; (2) discussions with Congressional staff familiar with the legislative history of the CPCP; (3) review of relevant documents for the C/MHC program and CPCP initiative including program guidance and application guidance memoranda, CPCP grant applications and application review protocols, and approved budgets and data on perinatal users for all FY 1988 CPCP grantees; (4) a review of recent relevant studies and evaluations of infant mortality and perinatal care services; and (5) census and infant mortality data from the National Center for Health Statistics, PHS.

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## FINDINGS

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*The goals and objectives set forth in CPCP grant proposals approved by PHS have been in accord with the intended purposes of the program.*

The purposes of the CPCP have been described in various Congressional documents, the announcements of available funds published in the *Federal Register*, and the application guidance developed and administered by PHS. Our review of these documents confirmed that PHS has approved CPCP grant proposals consistent with the intent of Congress, the criteria in the *Federal Register*, and the application guidance for the CPCP.

The PHS has reviewed and approved CPCP grant proposals consistent with the intent of Congress that CPCP funds be awarded to C/MHCs "to help them integrate and coordinate appropriate services throughout the pregnancy and first year of life in order to meet effectively the health care needs of mothers and infants."<sup>18</sup> The Congress hoped that an infusion of these funds would help reduce infant mortality consistent with the Surgeon General's goals for 1990.

The criteria PHS developed to evaluate the CPCP grant proposals were also consistent with those criteria summarized in the *Federal Register* and described in the application guidance for each year.<sup>19</sup> The PHS required applicants to submit proposals which addressed these criteria: the demonstrated effectiveness of existing perinatal care programs; a documented assessment of needs; an adequate and feasible plan to meet the needs; the extent to which the center is part of a coordinated system of care in its community; an adequate plan to evaluate the results of the services; and the appropriateness of the proposed budget.

Our analysis of the budgets for FY 1988 CPCP grantees indicates that, for those grantees for which information was available, the grantees' projected expenditures were in accord with the purposes outlined by Congress and described in the application guidance.<sup>20</sup> Case management, outreach services, health education, nutrition counseling, patient follow-up and transportation to prenatal appointments were among the services to be supported with CPCP funds. These grantees projected spending nearly three-fourths of their CPCP funds on personnel such as nurses, case managers, obstetricians and gynecologists, and social workers (see figure 1) to provide these services.

The present distribution pattern of CPCP funds is likely to be perpetuated through the consolidation of the CPCP and the C/MHC review and funding processes this year. The PHS will incorporate the level of CPCP support provided to the FY 1989 grantees into their "base" or basic level of 329/330 funding in FY 1990. This approach appears to be consistent with the intent of Congress,<sup>27</sup> and will provide reasonable assurance to grantees of more stable, long-term support for perinatal services. At the same time, however, PHS will have less flexibility in targeting these special funds to areas of highest need.

We acknowledge that the CPCP funds allocated to areas with infant mortality rates less than 12 deaths per 1,000 live births are nevertheless helping to address the nation's infant mortality problem. These areas may have pockets of higher infant mortality rates, which would not be reflected in the rates for the larger area. In some areas, the infant mortality rates may be increasing, even if they are still below 12 deaths per 1,000 live births. Also, the CPCP funds may help some areas to maintain their low rates. However, this distribution pattern raises a major policy question regarding how these scarce resources can best be directed in accord with the national concern about high infant mortality rates.

- Almost half of all community and migrant health centers have not applied for CPCP funds while others—including those serving areas with high infant mortality rates—have applied and have been disapproved.

Many centers funded through sections 329/330 of the Public Health Service Act—which by definition provide services in medically underserved areas—did not apply for CPCP funds in either FY 1988 or FY 1989. In fact, only slightly more than half of all centers applied for CPCP funding during either year, and not all applications were approved. In FY 1988, PHS was unable to approve approximately one-third of the CPCP applications. Among those disapproved were applications from at least 47 centers—almost half of all those disapproved—serving areas with infant mortality rates greater than 12 deaths per 1,000 live births. In FY 1989, PHS was unable to approve only about 15 percent of the CPCP applications. Twenty-six, or more than half, of the disapproved applications were from centers serving areas with infant mortality rates greater than 12.<sup>28</sup>

- Nearly half of the nation's largest cities with high infant mortality rates—greater than 12 deaths per 1,000 live births—have not been eligible for CPCP funds because they have no centers funded through sections 329/330 of the Public Health Service Act.

A significant number of the nation's largest cities—those with populations of 100,000 or more—have not participated in the CPCP initiative because they have lacked 329/330 community and migrant health centers—the required conduit for the CPCP funds. These major cities<sup>29</sup> are among the areas of the country experiencing the highest rates of infant mortality.

Nearly 40 percent of all infant deaths and slightly more than 60 percent of black infant deaths occurred in these cities in 1987. According to the National Center for Health Statistics, there

The extent to which these types of information will enable PHS to assess the impact of the CPCP initiative remains to be seen. As noted earlier, the program is still relatively new and these efforts are largely untested. The data from the perinatal user profiles, for example, do not specify the extent, types, or timing of perinatal services. Moreover, the progress reports we reviewed from FY 1988 grantees varied greatly in scope and quality. Finally, it is not clear at this time how PHS will account for the CPCP funds and assess their impact when the application review and funding processes are consolidated this year. Even now PHS has not required grantees to report on expenditures incurred specifically for CPCP supported services. Thus, the information specific to the CPCP funded services may not prove sufficient for adequately assessing the impact of the CPCP and assuring adequate accountability for this increasing investment of Federal funds.

***Many areas of the country with high rates of infant mortality have not been receiving CPCP funds.***

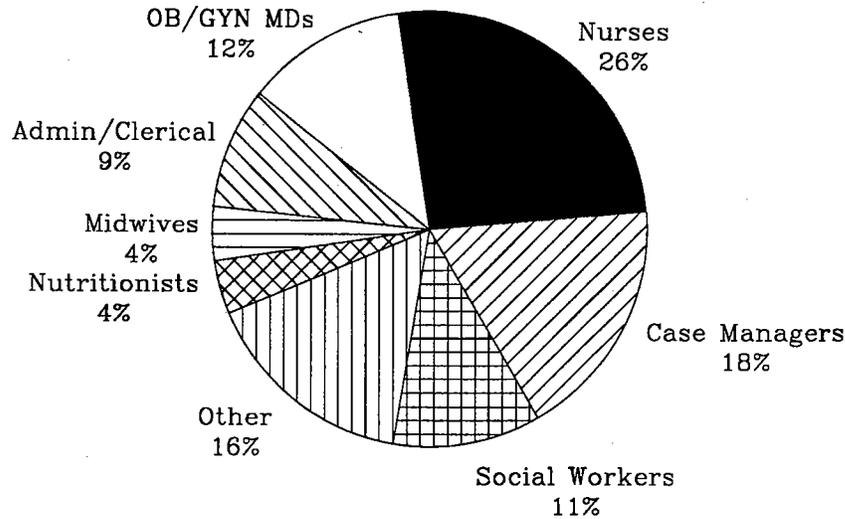
- Approximately 25 percent of CPCP funds have been awarded to community and migrant health centers serving areas with infant mortality rates below the threshold established by PHS for high infant mortality—12 deaths per 1,000 live births.

Approximately one in four CPCP dollars each year has been awarded to centers with service areas that have infant mortality rates less than 12 deaths per 1,000 live births for both the general and minority populations<sup>25</sup>—awards which involved sixty different centers. These rates are the levels above which PHS has considered the incidence of infant mortality to be high. In its 1990 Health Objectives for the Nation, formulated in 1980, PHS set as a goal that by 1990 no county and no racial or ethnic group of the population should have an infant mortality rate in excess of 12 deaths per 1,000 live births.<sup>26</sup> More recently, PHS used this same rate in its review of CPCP applications to define C/MHCs with service areas experiencing high infant mortality. Areas with rates higher than 12 were viewed as being in greater need of CPCP funds than areas with lower rates. However, nearly \$10 million of the CPCP funds over the past 2 years have been directed to centers serving areas with infant mortality rates not considered by PHS to be particularly high.

The PHS did consider the infant mortality rates of the areas served by centers when funding CPCP grantees. However, those rates considered high—above 12 deaths per 1,000 live births—were not heavily weighted in the funding process which included many other considerations.

Moreover, a sizeable number of centers serving areas with infant mortality rates below the national rate have received CPCP funds. As noted earlier, the national infant mortality rate in 1987 was 10.1 deaths per 1,000 live births. The PHS awarded CPCP funds to 27 centers each year with service areas where the infant mortality rates were less than 10 for both the general and minority populations.

**FIGURE 1**  
**Personnel Expenditures Projected by CPCP Grantees,**  
**Fiscal Year 1988**



Note: N=152 of 207 CPCP Grantee Budgets  
 Source: OIG/OEI analysis of FY 1988  
 data provided by U.S. PHS

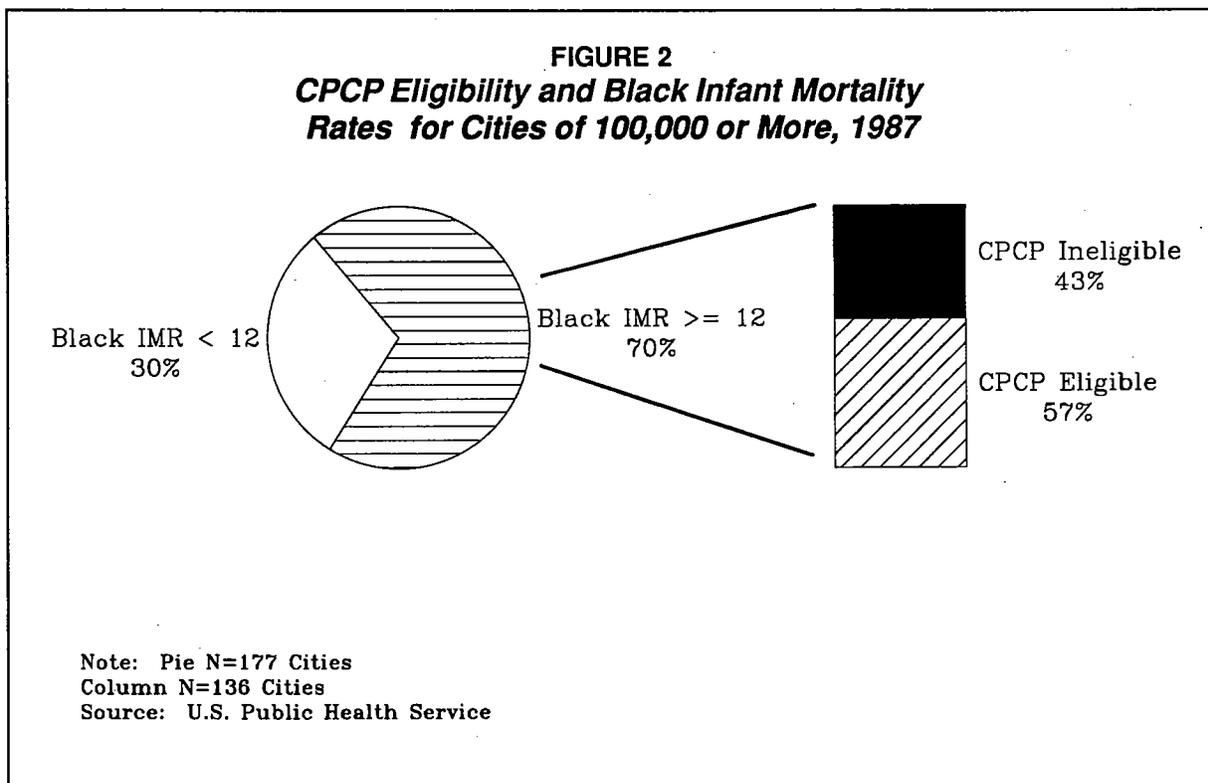
*In some cases, PHS had limited information on how grantees planned to spend the CPCP funds awarded during the first year.*

Our analysis of the approved budgets for first year grantees indicated that for slightly more than 25 percent of the grantees, PHS did not have budgets which clearly depicted the expenditures projected specifically for the CPCP funds. In most cases, PHS had to rely on revised budgets rather than the original grant applications for an accurate picture of the services to be provided and the types of expenditures planned. Although the original applications were the bases upon which PHS made approval and funding decisions, they usually did not accurately portray the CPCP services to be implemented. This was the case because, in most instances, the CPCP grants which were actually awarded by the PHS were significantly lower than the amounts requested and described by the applicants in their original applications.<sup>21</sup>

In some cases, CPCP funds were not distinguished from other types of funds in these revised budgets. In other instances, no itemized expenditures were projected for the CPCP funds, or the CPCP funds which were itemized did not total to the amount of the grant award as reported to us by PHS. Without this documentation, PHS could not know the specific perinatal services to be supported with CPCP funds.

were 177 cities with populations of 100,000 or more in 1987. There were 38,408 infant deaths nationally in 1987; 15,140 (39 percent) of these deaths occurred in these 177 cities. There were 11,461 infant deaths among blacks nationally in 1987; 7,080 (62 percent) of these deaths occurred in these 177 cities.

Among the cities of 100,000 or more population, 43 percent of those having high rates of infant mortality for blacks in 1987 were not eligible for CPCP funds the first year because they had no 329/330 community or migrant health centers (see figure 2). Likewise, among these large cities, 40 percent of those having high rates of infant mortality for the general population were also not eligible.<sup>30</sup> In fact, of the ten cities in the country with the highest infant mortality rates, two of them—Richmond and Portsmouth, Virginia—were among those without 329/330 community and migrant health centers and thus not eligible to receive CPCP funds.



It is important to note that less than half—approximately 40 percent—of the community and migrant health centers are located in urban areas.<sup>31</sup> Yet urban areas nationally have had higher rates of infant mortality than rural areas, although, to be sure, some rural areas have indeed had high rates of infant mortality. Not only have the rates of infant mortality been higher in urban areas than in rural areas, but so too has the incidence of infant death. Indeed, at least 3.5 times as many infant deaths occurred in metropolitan areas as in non-metropolitan areas during the 3-year period 1985-1987.<sup>32</sup> Thus, because CPCP funds have been limited to 329/330 community and migrant health centers, many large cities with high need but without such centers have not received CPCP funded services.

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## RECOMMENDATIONS

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In light of the situation described in the previous pages, we offer the following recommendations to the PHS with respect to its management of the CPCP initiative.

***The PHS should strengthen its procedures for approving CPCP grants to assure adequate accountability for CPCP funds.***

It is essential that the approval process for CPCP grants assures that PHS has specific, comprehensive, and up-to-date information on how CPCP grantees plan to spend their grant funds. This information is essential for assuring the financial integrity of the CPCP and for assessing the impact of the program.

***The PHS should strengthen its efforts to provide technical assistance to community and migrant health centers preparing CPCP grant proposals.***

As we have seen, many centers have not applied for CPCP funds; others serving areas with high infant mortality rates have had their proposals disapproved. We encourage PHS to strengthen its technical assistance to these centers so that more of them apply for CPCP funds with high quality grant proposals.

***The PHS should reexamine the approach for allocating CPCP funds to assure that these funds are directed to areas of high infant mortality.***

The CPCP has been a significant new initiative in the Department's continuing efforts to reduce the country's high rates of infant mortality. With considerable support from Congress, the CPCP has offered PHS an opportunity to direct specially appropriated funds into services aimed at reducing infant mortality in the low income, medically underserved areas served by the centers.

We urge the PHS to reexamine the approach to allocating the CPCP funds. Our analysis raises important policy issues regarding whether these CPCP monies are being directed in the most strategic manner and whether continuation of the present pattern of allocating these funds will best serve the intent of this initiative. Resources are scarce, and the need for improved perinatal services is great in many areas of the country. Yet, as we have seen, a substantial portion of CPCP funds—about 25 percent in both FY 1988 and FY 1989—has not been directed to areas experiencing high rates of infant mortality. Moreover, many areas of high need, including many large cities of the country, have been deprived of CPCP supported services—either because they have lacked a 329/330 community or migrant health center or because the center's application for CPCP funds has been disapproved.

Among the important policy questions to consider are the following. Should infant mortality rates figure more prominently in the application and funding process for CPCP funds? Should any increases in the CPCP appropriations be more selectively targeted to centers serving areas

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## COMMENTS ON THE DRAFT REPORT AND OIG RESPONSE

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We received comments on the draft report from the Assistant Secretary for Planning and Evaluation (ASPE) and the Public Health Service (PHS). The comments are contained below in their entirety and are followed by the OIG response.

### COMMENTS FROM ASPE

As you know, reducing infant mortality has been a Departmental priority for a number of years. We have seen numerous maternal and child health demonstrations and program expansions arrive with great promise, only to observe no change in infant mortality and morbidity rates.

The report on the CPCP was particularly useful in terms of evaluating our policy direction since it appears that the funding may not have gone to the highest priority areas, not all the potential funding candidates applied for assistance, and we lack the information necessary to evaluate CPCP's impact. The recommendations of the draft report point out that an innovative idea may not meet its full potential because of serious administrative failures.

### OIG RESPONSE

*We are pleased with ASPE's concurrence with our recommendations.*

### COMMENTS FROM PHS

Attached are the PHS comments on the subject OIG draft report.

We concur with the report's recommendations to (i) improve PHS technical assistance to comprehensive perinatal care program (CPCP) grantees and approval process for grant proposals, and (ii) reexamine the approach for allocating funds to areas of high infant mortality rates.

We are now reviewing strategies to improve program accountability, and target technical assistance to grantees in areas of high infant mortality rates. We will consider alternative strategies (other than CPCP) to fund perinatal activities at current CPCP sites at which infant mortality rates and other indicators reflect lesser need. This will assure that continued eligibility for CPCP funding is based on highest need.

### OIG RECOMMENDATION

*The PHS should strengthen its procedures for approving Comprehensive Perinatal Care Program (CPCP) grants to assure adequate accountability for CPCP funds.*

with the highest rates of infant mortality? How might perinatal services be supported more intensively in those very needy areas without community or migrant health centers? Is it a more effective use of limited resources to fund many centers in modest amounts or to target fewer centers in the neediest areas for more substantial support? As the Federal investment in the CPCP continues to increase each year and as evaluation findings become available, we urge PHS to consider questions such as these in order that the limited dollars available for the CPCP achieve the maximum impact on this most pressing problem of infant mortality.

## **COMMENT FROM PHS**

We concur. PHS is reviewing alternative strategies which optimize program accountability and which also are sensitive to the grantee's administrative burden of submitting applications for the Community and Migrant Health Center (C/MHC)-Programs as well as the CPCP. Currently, CPCP and C/MHC grantees use a single budget which combines dollars for both programs. By the end of Fiscal Year 1991, PHS will require separate budgeting of CPCP costs. In cases where that CPCP award differs from the original request, PHS will require a revision of the CPCP budget.

### **OIG RECOMMENDATION**

*The PHS should strengthen its efforts to provide technical assistance to Community and Migrant Health Centers preparing CPCP grant proposals.*

## **COMMENT FROM PHS**

We concur. PHS plans to strengthen its efforts by targeting technical assistance to C/MHCs in areas of highest infant mortality which have not yet been able to develop an approved and funded application. By October 1990 PHS will identify and prioritize key cities that have high infant mortality rates and do not have any CPCP grants. By November 1990 PHS will define priority areas to develop successful CPCP proposals. The plan will draw on regional clinical expertise. In addition, PHS will target a portion of Fiscal Year 1991 CPCP appropriations, which are in excess of the amount required for continuation grantees, to fund new CPCP grants at C/MHCs in areas with the highest infant mortality rates.

### **OIG RECOMMENDATION**

*The PHS should reexamine the approach for allocating CPCP funds to assure that these funds are directed to areas of high infant mortality.*

## **COMMENT FROM PHS**

We concur. We have targeted and will continue to target CPCP resources to areas of greatest need by considering county infant mortality rates and other indicators of local area need. By December 1990, PHS will consider alternative strategies (other than CPCP) to fund perinatal activities at current CPCP sites at which infant mortality rates and other indicators reflect lesser need. This will assure that continued eligibility for CPCP funding is based on highest need.

Many areas without C/MHCs have high infant mortality rates, and on this basis the draft report suggests broadening eligibility for CPCP funding. Current appropriation language prohibits this. However, PHS will identify areas with exceptional need, including perinatal, human immunodeficiency virus, and other excessive health risks, to receive priority consideration should funds become available for new C/MHC and CPCP awards. In addition, PHS will explore the possibility of coordinating infant mortality reduction efforts with those of other relevant programs.

We believe that limited CPCP funds can be most effectively utilized by targeting community-based primary care systems. These systems are well established in C/MHCs. To do otherwise deletes the cumulative impact of the C/MHC and CPCP initiatives.

**OIG RESPONSE TO PHS COMMENTS**

*We appreciate PHS' positive response to our recommendations.*

*We are pleased that beginning in FY 1991 PHS will require grantees to budget separately for CPCP costs and to revise grant budgets in cases where the actual award differs from the amount requested. We think it is important that in the future these revised budgets, which were required in FYs 1988 and 1989, clearly itemize those expenditures proposed exclusively for the CPCP services.*

*Further, we wish to clarify that the draft report did not specifically call for broadening eligibility for CPCP funding. Rather, we expressed concern that many areas of the country with high rates of infant mortality lacked C/MHCs. Therefore, we suggested that PHS consider, among other issues, how perinatal services in those areas might be supported more intensively.*

*Finally, we are particularly pleased that PHS is reexamining its approach for allocating CPCP funds to assure that these limited funds are targeted to areas of highest need.*

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## APPENDIX A

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### ENDNOTES

1. Infant mortality refers to infant deaths before age one.

Kathleen McCormick, "Prenatal Care: Rationing the Risks," *Medicine & Health*, 43(47), Faulkner & Gray's Health Care Information Center, Washington, D.C., December 4, 1989.

2. *Medicare and Medicaid Guide*, Number 597, Commerce Clearing House, Inc., Chicago, Illinois, October 11, 1989, p. 8.

3. "Prenatal Care," op. cit.

4. Infants born weighing less than 2,500 grams are low birth weight infants. These infants are as much as 40 times more likely to die in the first month of life than normal weight infants.

The National Commission to Prevent Infant Mortality, "Death Before Life: The Tragedy of Infant Mortality," August, 1988, p. 23.

5. *Medicare & Medicaid Guide*, op. cit.

6. National Center for Health Statistics, Centers for Disease Control, Public Health Service, Department of Health and Human Services.

7. "Prenatal Care," op. cit.

8. U.S. Public Health Service, "The 1990 Health Objectives for the Nation: A Midcourse Review," 1986, pp. 36-37.

The Department of Health and Human Services recently released the draft objectives for the year 2000, including that the national infant mortality rate not exceed 7 deaths per 1,000 live births and that the black infant mortality rate not exceed 11 deaths per 1,000 live births.

U.S. Public Health Service, "Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation," Draft Report, September, 1989, p. 11-3.

9. "Death Before Life," op. cit.

10. The set-aside provision requires that two-thirds of 12.75 percent of MCH block grant appropriations be set aside for infant mortality initiatives.

U.S. Congress, House, *Omnibus Reconciliation Act of 1989*, 101st Cong., 1st sess., HR 3299, *Congressional Record*, Vol. 135, no. 165, Daily ed. (November 21, 1989), H9472-H9473.

11. "Death Before Life," pp. 64-65.
12. John Snow, Inc., "Perinatal Care: How to Establish Perinatal Services in Community Health Centers," August, 1985, p. 2.
13. "Death Before Life," p. 7.
14. Contract No. HRSA 240-87-0056, La Jolla Management Corporation, "Perinatal Care in Communities Served by Community and Migrant Health Centers," Columbia, Maryland, 1989, p. ii.
15. U.S. Senate, Report No. 100-189, "Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriation Bill, 1988," October 1, 1987.  
  
U.S. Senate, Report No. 100-343, "Community and Migrant Health Centers Amendments of 1988," Public Law 100-386, August 10, 1988.
16. The PHS reviewed grant applications once each year in a process involving review teams in both the regions and headquarters. Final award decisions were made in headquarters.
17. Bowen, Otis R., M.D., Fiscal Year 1990 Budget Press Conference, January 9, 1989.
18. U.S. Senate, Report No. 100-343, op. cit.
19. 53 FR 11345-11347.  
  
54 FR 5679-5681.  
  
U.S. Public Health Service, "Supplemental Grants for the Development of a Comprehensive Perinatal Care Program in Community and Migrant Health Centers: Application Guidance," 1988.  
  
U.S. Public Health Service, "Comprehensive Perinatal Care Program-Regional Guidance Memorandum 89-4," March 8, 1989.  
  
U.S. Public Health Service, "Comprehensive Perinatal Care Program-Grant Application Review Process, Regional Guidance Memorandum 89-6," April 28, 1989.

20. We requested the approved budgets for all FY 1988 CPCP grantees from the ten PHS Regional Offices. This analysis is based on the budgets for 152 of the 207 FY 1988 grantees. Budgets from the remaining FY 1988 grantees were not sufficiently specific to be included. This analysis was limited to FY 1988 grantees because data for the FY 1989 grantees was not yet available.
21. Ninety-one percent of FY 1988 grantees and 90 percent of FY 1989 grantees were awarded CPCP funds in amounts lower than the sums they had requested. In both years, the average grant award was nearly 60 percent less than the average request. The average request in FY 1988 was \$232,996; the average amount awarded was \$96,325. In FY 1989, the average request was \$182,140; the average award was \$73,508. The FY 1989 grantees were awarded funds for periods ranging from 3 to 15 months in order that they terminate on the last day of the centers' grant periods for basic 329/330 funding.
22. The PHS has imposed few reporting requirements on grantees regarding their CPCP funds—an approach favored by the Congress in order that the new services be initiated as quickly as possible. (U.S. Senate, Report No. 100-343, op. cit.)
23. Contract No. HRSA 240-87-0056, "Perinatal Care in Communities Served by Migrant and Community Health Centers," op. cit.
24. U.S. Senate Report No. 100-343, op. cit.
25. Our analysis is based on infant mortality rates for the centers' service areas provided to us by PHS. These rates were used by PHS when making funding decisions for CPCP grant awards. The PHS calculated infant mortality rates for each center based on infant mortality rates aggregated by county. The PHS acknowledges that these calculated rates are thus estimated rates for each center because the center's specific service area may be larger or smaller than the county(ies) included in the calculations.
26. "The 1990 Health Objectives for the Nation," op. cit.
27. U.S. Senate, Report No. 101-127, "Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act of 1990," Public Law 101-166, November 21, 1989, pp. 53 and 55.
28. This analysis is based on infant mortality rates provided by PHS. The data for FY 1988 is incomplete because rates were not available for all centers and data on disapproved applications was not available for one region.
29. "Prenatal Care," op. cit.

30. This analysis is based on infant mortality data for 1987 from the National Center for Health Statistics, PHS. Data on community and migrant health centers are from the Bureau of Health Care Delivery and Assistance (BHCDA), PHS.

Among the 177 cities with populations of 100,000 or more, 136 cities had black infant mortality rates greater than or equal to 12 deaths per 1,000 live births; 58 of these 136 cities were ineligible for CPCP funds.

Among these 177 cities, 74 cities had general infant mortality rates greater than or equal to 12; 30 of these 74 were ineligible for CPCP funds.

31. "Death Before Life," p. 63.
32. Based on infant mortality data for 1985-1987 provided by the National Center for Health Statistics, PHS.